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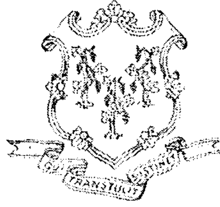

State of Connecticut

SENATE

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SENATE REPUBLICAN OFFICES

Representative Scanlon, Senator Larson, Senator Kelly, Representative Sampson and distinguished members of the Insurance and Real Estate Committee, thank you for raising and for the opportunity to testify on several bills before your committee today. These bills have bipartisan support, and we want to thank Senate President Pro Tempore Martin Looney and Senator Gerratana for their work on these issues as well.

S.B. 379 An Act Limiting Changes to Health Insurer's Prescription Drug Formularies

Changes to prescription drug coverage mid policy term can be extremely burdensome for patients resulting in increased costs, disruption of treatment and sometimes negative health outcomes. A recent article by the Pew Charitable Trusts highlights the case of a young woman whose depression was successfully treated with the drug Pexeva. However, when her insurer moved the drug to a higher price tier and refused her physician's request to continue to cover the drug on the same terms, she was forced onto a lower cost but less effective drug. Soon after, her manic episodes returned with serious debilitating effect. Not just her mental health, but everything in her life suffered including her school work, family life and physical health as she suffered severe physical side effects. (http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/02/02/new-rules-aim-to-keep-patients-on-medications-that-work)

Stories like this have led several states, including Louisiana, Nevada, New Mexico and Texas, to adopt legislation prohibiting or severely restricting the ability of an insurer to remove a drug from its formulary or alter the terms of coverage during a policy term. Several more states, including New York, Maryland, Florida and Tennessee have proposals pending. Medicare also prohibits such mid-year changes. (https://www.cga.ct.gov/2017/rpt/pdf/2017-R-0203.pdf)

Proponents of these proposals, including Florida Republican State Representative Ralph Massullo, point out that many patients choose a health plan based on its medication formulary Changes to that formulary in the middle of a policy term force the patient to choose between paying more for the drug recommended by their physician or gambling on a new medication. They cannot simply change health plans in the same way the insurer simply changed its formulary.

Studies have shown that non-medical medication switching leads to higher non-drug health spending and negative health outcomes. An analysis by the Institute for Patient Access, a national network of physicians, found that insurer driven drug switching can lead to higher non-drug health care expenditures and that continuity of care actually keeps costs lower. According to the report, "this new research suggests the long-term costs may outweigh the short-term benefits that health plans seek." Similarly, a study published in the Journal of Family Practice found that insurance driven medication changes led to "a mix of adverse outcomes, decreased satisfaction, and increased practice burdens." (http://allianceforpatientaccess.org/press-release-non-medical-switching-analysis-finds-higher-health-care-costs-after-patients-were-driven-to-lower-cost-drugs/ ; https://www.mdedge.com/jfponline/article/64770/practice-management/effect-insurance-driven-medication-changes-patient-care)

SB 379 would begin to address this issue, not by completely prohibiting mid-term formulary changes, but by ensuring that (1) patients and providers receive sufficient advance notice of such changes and (2) the patient is allowed to remain on the effected drug on the same terms and conditions through the policy term if the provider determines that such drug is the best treatment option for the patient.

This is not only a matter of contractual fairness but an important public health and total health care cost issue.

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S.B. 380 An Act Requiring Health Insurance Coverage of a Prescribed Drug During Adverse Determination Reviews and External Review Processes

Senate Bill 380 would ensure patient access to covered medications during the course of any internal or external appeal. This bill does not require an insurer to cover any medication it is not already covering or that is ultimately determined not to be medically necessary. However, when a patient has paid for a policy that covers certain medication and has gone to a participating provider who determines that a covered medication is necessary, the patient should have access to that medication unless and until it is finally determined that the medication is, in fact, not medically necessary. The insurance company should not be able to override or substitute its medical judgment for that of the provider unless and until the appeal process has been completed. As previously discussed, medication changes and substitutions can have serious negative consequences in terms of health outcomes and total health care costs.

The need for this provision has become all the more obvious in light of recent revelations by a health insurance medical director in California. The doctor acknowledged under oath that he routinely denied coverage for physician ordered treatment without ever reviewing the patients' medical records and often without professional expertise or knowledge of the patients' specific medical condition. California's Insurance Commissioner was quoted as saying *"If the health insurer is making decisions to deny coverage without a physician actually ever reviewing the medical records, that's of significant concern to me ... and a potential violation of the law."* Since these revelations, several state insurance commissioners, including Commissioner Wade, have promised to investigate these practices.
https://www.cnn.com/2018/02/11/health/aetna-california-investigation/index.html *("California Launches Investigation Following Stunning Admission By Aetna Medical Director")*;
http://www.modernhealthcare.com/article/20180215/NEWS/180219943 *("Six State Regulators Now Scrutinizing Aetna Prior-authorization Practices")*

Cursory and unsupported denials of medical coverage are clearly inappropriate. Given that the insurer has accepted premium payments in return for a promise to cover certain medically necessary services and medication, yet has a financial incentive to deny coverage, it seems appropriate to protect the patient's access to doctor prescribed covered drugs until the appeal process has been completed. It also seems appropriate to give the benefit of the doubt during the appeal to the patient's own treating physician, rather than allow the insurer to substitute its medical judgment and risk unnecessary and perhaps dangerous medication changes.

S.B. 378 An Act Concerning Reimbursements Under Certain High Deductible Plans

With the increasing prevalence of high deductible plans, more services, including costly and complex medical procedures and surgeries, fall under a policy's deductible. While the insured is paying premiums to the insurer and has agreed to pay for services under the plan's deductible, it is left to the provider to bill and collect payment from their patient.

Physicians are seeing a significant increase in administrative costs, lost revenue and bad debt associated with attempting to collect payment from their patients for services covered by high deductible plans. Doctors are understandably reluctant to pursue aggressive bill collection actions against their patients. The financial strain this is causing is just one more thing making it difficult to sustain physician practices in Connecticut. The situation also puts a strain on the doctor patient relationship and creates an incentive for patients to avoid necessary care or hop from one physician to another, neither of which is in the best interests of the patient.

Insurers have the financial relationship and contract with the insured that requires payment for these services. They are already collecting premiums and have the administrative and other resources available to collect payment from their policy holders. The insurer also has a contract with the participating physician that requires the physician to provide covered services at the negotiated rate. Therefore, we believe it makes sense for the insurer to pay for covered medical services that fall within an insured's deductible and then bill their insureds for the amount so paid.

We also want to comment on some of the other bills on your agenda today:

H.B 5383 An Act Concerning Disputes Between Health Carriers and Participating Providers That Are Hospitals addresses contract disputes between hospitals and health plans. As we all know, recent lengthy and acrimonious disputes

between large health systems and major insurers, such as the Anthem/Hartford Health Care dispute, caused tremendous anxiety and uncertainty among patients, particularly patients with chronic conditions requiring ongoing treatment and pregnant women. When notices went out informing patients that services from their hospital or doctor would no longer be covered, we all got calls from our constituents worried about out of pocket costs or having to switch doctors in the middle of a policy term. This bill would attempt to create the breathing room necessary to foster an amicable resolution between the parties by creating a sixty day cooling off period during which services would continue to be covered while the parties negotiate. It also increases the notice required before a provider may leave or be terminated from a plan. This seems to be a reasonable step to encourage the parties to resolve their differences without direct state involvement.

H.B. 5384 An Act Concerning Prescription Drug Costs promotes greater transparency regarding drug costs across the entire supply chain, including pharmaceutical manufacturers, pharmacy benefit managers, and insurers. Increasing drug costs have frustrated consumers and policy makers for years and recently there has been much finger pointing between the various players as to who is most to blame. To the extent this bill seeks to gather relevant information from all sources regarding certain high cost drugs to inform both the public and policy makers, it seems to be a reasonable step. There is no silver bullet to this issue and the answer is not necessarily government regulation. However, with health care costs representing an ever increasing portion of our economy and prescription drugs contributing to that, understanding what factors are driving those costs in order to determine what if anything we can do about it as policy makers, is important. We want to be sure that any reporting framework focuses on relevant and actionable information and gives a complete picture by including all major segments of the industry. It should be as minimally burdensome as possible. We want to thank those who have been working on this issue, including Chairman Scanlon.

Thank you for your time and attention, and we look forward to working with you on these important issues.

Len Fasano
Senate Republican President Pro Tempore

Heather Somers
State Senator-18th District (CT)